STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495286	A. BUILDING _____ B. WING _____	C 04/18/2019

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JAMES RIVER CONVALESCENT CENTE	540 ABERTHAW AVENUE NEWPORT NEWS, VA 23601

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 04/16/19 through 04/18/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 04/16/19 through 04/18/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey. The census in this 154 certified bed facility was 141 at the time of the survey. The survey sample consisted of 41 current Resident reviews and 5 closed record reviews.	F 000		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is	F 622		5/17/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/02/2019

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endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record

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F 622	Continued From page 2 must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility documentation review, the facility staff failed to convey the summary of goals of the comprehensive plan of care upon transfer/discharge for 6 of 46 residents (Resident #134, #52, #81, #80, #106 and #50) in the survey	F 622	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas	

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F 622	Continued From page 3 sample. 1. The facility staff failed to include in the transfer summary indication that the facility staff conveyed to the receiving provider the resident's comprehensive care plan goals at the time of discharge to the local hospital on 3/8/19 and 3/28/19 or as soon as possible to the actual time of transfer for Resident #134. 2. The facility staff failed to include in the transfer summary indication that the facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge to the local hospital on 2/8/19 or as soon as possible to the actual time of transfer for Resident #52. 3. The facility staff failed to include in the transfer summary indication that the facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge to the local hospital on 3/15/19 and emergency department on 3/20/19 or as soon as possible to the actual time of transfer for Resident #81. 4. The facility staff failed to include in the transfer summary indication that the facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge to the local hospital on 4/6/18 and on 5/22/18 or as soon as possible to the actual time of transfer for Resident #80. 5. The facility staff failed to send Resident #106's care plan summary to the receiving facility when discharged to the hospital on 01/03/2019.	F 622	cited have been made and the facility is in compliance with participation requirements. 1. Residents' number #134, #52, #81, #80, #106, and #50 all returned from the Emergency Room or the hospital, therefore no corrective action can be taken with the residents at this time. 2. Residents that transferred to the Emergency or admitted into the hospital in the last 30 days and remain in the Emergency Room or the hospital will be reviewed to ensure if the Transfer Summary, which includes the comprehensive care plan summary and goals, was sent with the resident. Any variances identified will be corrected. 3. The Director of Nursing/Designee will reeducate RNs and LPNs on conveying the Transfer Summary Report, which contains the comprehensive care plan and goals, and documenting in the clinical record the information was provided with the resident upon transfer or discharge to the hospital. 4. The Director of Nursing/Designee will review 20% of Emergency Room transfer or hospital discharges for six weeks to ensure the Transfer Summary Report which contains the comprehensive plan of care was sent and documented in the nursing notes. The Director of Nursing/Designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly.	

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6. The facility staff failed to ensure that Resident #50's Plan of Care Summary to include care plan goals, was sent upon transfer/discharge to the hospital on 01/03/19 and 2/3/19

The findings include:

1. The facility staff failed to include in the transfer summary indication that the facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge to the local hospital on 3/8/19 and 3/28/19 or as soon as possible to the actual time of transfer for Resident #134.

Resident #134 was admitted to the nursing facility on 12/5/05 with diagnoses that included adult failure to thrive, fractured right tibia and high blood pressure.

Resident #134's most recent Minimum Data Set (MDS) assessment was a significant change in status assessment dated 3/21/19 and coded the resident with a score of 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was fully intact in the cognitive skills necessary for daily decision making.

The nurse's notes dated 3/8/19 indicated the resident fell on the floor and complained of pain in her right knee. Based on continued complaints of pain, the resident was transported to the ED and admitted to the hospital on 3/8/19. Resident #134 was readmitted to the nursing facility on 3/30/19. There was no documentation in the clinical record that facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge or soon thereafter

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to the local hospital.

The nurse's notes dated 3/28/19 indicated the resident was transported to the local hospital for surgery. Resident #134 was readmitted to the nursing facility on 3/30/19. There was no documentation in the clinical record that facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge or soon thereafter to the local hospital.

On 4/18/19 at 1:10 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #3. She stated she sent transfer paperwork, but the paperwork did not include a care plan summary.

On 4/18/19 at approximately 5:00 p.m., the Administrator and Director of Nursing (DON) stated that could not provide evidence that the care plan summary was sent to the hospital. They said, "When a resident is transferred to the ER or the hospital the nurse is prompted through a check list in the computer for the specific resident that in turn generates the transfer summary that includes the care plan summary with goals as well as the bed hold notice, but there is no way to confirm the documents was sent at the time of the transfer or that it was sent over to the ED or hospital soon after. We had in-services that instructed the nurse to document in the nurse's notes the summaries and bed hold notices were sent. We actually see some nurses are documenting but others are not and there is a lack of consistency. We will continue to re-educate all our nurses."

The Administrator or DON did not present any

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additional documentation prior to survey exit on 4/18/19 at 7:00 p.m.

2. The facility staff failed to include in the transfer summary indication that the facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge to the local hospital on 2/8/19 or as soon as possible to the actual time of transfer for Resident #52.

Resident #52 was admitted to the nursing facility on 12/6/17 with diagnoses that included chronic kidney disease with hemodialysis, left kidney malignant neoplasm, high blood pressure stroke.

The resident's most recent Minimum Data Set (MDS) assessment was a significant change in status assessment dated 12/17/18 and coded the resident with a score of 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was fully intact in the skills necessary for daily decision making.

The nurse's notes dated 2/8/09 indicated the resident was being sent to the local emergency department (ED) from the dialysis center. The resident returned to the nursing facility on 2/13/19. There was no evidence that the care plan summary was forwarded to the local hospital on 2/8/19 or as soon as possible thereafter.

On 4/18/19 at approximately 5:00 p.m., the Administrator and Director of Nursing (DON) stated that could not provide evidence that the care plan summary was sent to the hospital. They said, "When a resident is transferred to the ER or the hospital the nurse is prompted through a

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check list in the computer for the specific resident that in turn generates the transfer summary that includes the care plan summary with goals as well as the bed hold notice, but there is no way to confirm the documents was sent at the time of the transfer or that it was sent over to the ED or hospital soon after. We had in-services that instructed the nurse to document in the nurse's notes the summaries and bed hold notices were sent. We actually see some nurses are documenting but others are not and there is a lack of consistency. We will continue to re-educate all our nurses." They added that they would have to make sure when residents are sent to the ED and or admitted to the hospital from a doctors office or dialysis, the transfer summaries are sent over that included the same aforementioned information.

The Administrator or DON did not present any additional documentation prior to survey exit on 4/18/19 at 7:00 p.m.

3. The facility staff failed to include in the transfer summary indication that the facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge to the local hospital on 3/15/19 and emergency department on 3/20/19 or as soon as possible to the actual time of transfer for Resident #81.

Resident #81 was admitted to the nursing facility on 3/1/19 with diagnoses that included stroke, pathological fracture and high blood pressure.

The resident's most recent Minimum Data Set (MDS) assessment was an admission assessment and coded the resident with a score

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of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was fully intact in the skills necessary for daily decision making.

The nurse's notes dated 3/15/19 indicated Resident #81 was transferred to the local emergency department and admitted to the hospital for blood in the urine, pain and burning sensation. The resident was readmitted to the nursing facility on 3/16/19. There was no evidence that the care plan summary was forwarded to the local hospital on 3/15/19 or as soon as possible thereafter.

The nurse's notes dated 3/20/19 indicated Resident #81 was transferred to the local ED due to replacement of indwelling urinary catheter. The resident returned to the nursing facility on 3/20/19. There was no evidence that the care plan summary was forwarded to the local hospital on 3/20/19 or as soon as possible thereafter.

On 4/18/19 at approximately 5:00 p.m., the Administrator and Director of Nursing (DON) stated that could not provide evidence that the care plan summary was sent to the hospital. They said, "When a resident is transferred to the ER or the hospital the nurse is prompted through a check list in the computer for the specific resident that in turn generates the transfer summary that includes the care plan summary with goals as well as the bed hold notice, but there is no way to confirm the documents was sent at the time of the transfer or that it was sent over to the ED or hospital soon after. We had in-services that instructed the nurse to document in the nurse's notes the summaries and bed hold notices were sent. We actually see some nurses are

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documenting but others are not and there is a lack of consistency. We will continue to re-educate all our nurses."

The Administrator or DON did not present any additional documentation prior to survey exit on 4/18/19 at 7:00 p.m.

4. The facility staff failed to include in the transfer summary indication that the facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge to the local hospital on 4/6/18 and on 5/22/18 or as soon as possible to the actual time of transfer for Resident #80.

Resident #80 was admitted to the nursing facility on 3/16/18 with diagnoses that included kidney failure, atrial fibrillation, pressure ulcers, stroke and peripheral vascular disease (PVD).

The resident's most recent Minimum Data Set (MDS) assessment was an admission assessment and coded the resident with a score of 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was fully intact in the skills necessary for daily decision making.

Resident #80 was admitted to the local hospital on 4/6/18 and readmitted to the nursing facility on 4/10/18. There was no evidence that the care plan summary was forwarded to the local hospital on 4/6/19 or as soon as possible thereafter.

Resident #80 was admitted to the local hospital on 5/22/19 and readmitted to the nursing facility on 5/29/18. There was no evidence that the care plan summary was forwarded to the local hospital

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on 5/22/19 or as soon as possible thereafter.

On 4/18/19 at approximately 5:00 p.m., the Administrator and Director of Nursing (DON) stated that could not provide evidence that the care plan summary was sent to the hospital. They said, "When a resident is transferred to the ER or the hospital the nurse is prompted through a check list in the computer for the specific resident that in turn generates the transfer summary that includes the care plan summary with goals as well as the bed hold notice, but there is no way to confirm the documents was sent at the time of the transfer or that it was sent over to the ED or hospital soon after. We had in-services that instructed the nurse to document in the nurse's notes the summaries and bed hold notices were sent. We actually see some nurses are documenting but others are not and there is a lack of consistency. We will continue to re-educate all our nurses."

The Administrator or DON did not present any additional documentation prior to survey exit on 4/18/19 at 7:00 p.m.

5. The facility staff failed to send Resident #106's care plan summary to the receiving facility when discharged to the hospital on 01/03/2019.

Resident #106 was discharged to the hospital on 01/03/2019 and readmitted to the facility on 01/08/2019. Diagnosis included but were not limited to, Multiple Sclerosis, Quadriplegia and Hypertension.

Resident #106's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 03/23/2019 coded Resident

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#106 with a BIMS (Brief Interview for Mental Status) score of 14 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #106 as requiring total assistance with Activities of Daily Living.

On 04/18/2019 at 5:20 p.m., an interview was conducted with the Director of Nursing (DON). The DON was asked, "Was Resident #106's care plan summary sent to the hospital upon discharge?" The DON stated, "No, there is no documentation to support that it was sent." The DON stated, "Nursing usually sends a Transfer Clinical Summary with residents when transferring them to the hospital which includes the care plan and Bed Hold Notice. However, there is no documentation stating that it was sent."

The administrative team was informed of the finding on 04/18/2019 at approximately 6:30 p.m. No further information was provided about the finding.

6. Resident #50 was originally admitted to the facility on 12/05/13. The resident was re-admitted to the facility on 11/29/18 and 01/08/19. Diagnosis for Resident #50 included but not limited to *Dementia and *Type II Diabetes.

Resident #50's current Minimum Data Set (MDS), a significant change with an Assessment Reference Date (ARD) of 02/14/19 coded the resident with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions.

The Discharge MDS assessment dated 11/25/18

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- discharge return anticipated, resident re-admitted on 11/29/18.

The Discharge MDS assessment dated 01/03/19- discharge return anticipated, resident re-admitted on 01/08/19.

On 11/25/18 at approximately 3:31 a.m., according to the facility's documentation, "Per order from the on call Physician Assistant (PA), new order obtained to send Resident #50 to the local Emergency Room (ER) for a critical lab Sodium level of 169." Resident #50 was re-admitted to the nursing facility on 11/29/18.

On 01/03/19 at approximately 3:03 p.m., according to the facility's documentation, "Nurse Practitioner (NP) in to assess resident with new orders to send to local ER after speaking to daughter to see what she decides." The daughter wanted to send Resident #50 to the ER. The daughter has declined hospice at this time. The resident was transported to the local ER via Life Care transportation. Resident #50 was re-admitted to the nursing facility on 01/08/19.

An interview was conducted with the Administrator and Director of Nursing (DON) on 04/18/19 at approximately 5:00 p.m. The DON said he was unable to locate documentation in Resident #50's clinical record that the care plan summary was sent when discharged to the hospital on 11/25/18 and 01/03/19. The DON said when a resident is transferred to the hospital; the nurse will complete a checklist in the computer that will prompt the nurse to check the care plan summary for that resident. The checklist is converted into a Transfer Clinical Summary. The Transfer Clinical Summary if

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F 622	Continued From page 13 completed correctly will include the residents current care plan with the their problems and care plan goals. The DON stated, "Since, we were unable to locate documentation in the residents clinical record, I cannot say the residents care plan summary was sent with Resident #50 when discharged to the hospital on 11/25/18 and 01/03/19." The facility administration was informed of the finding during a briefing on 04/18/19 at approximately 6:25 p.m. The facility did not present any further information about the findings. The facility's policy titled Admission, Transfer & Discharge Rights Policy (Last revision date: 01/25/17). Definitions: *Dementia is the name for a group of symptoms caused by disorders that affect the brain. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there (https://medlineplus.gov/ency/article/007365.htm). *Diabetes Mellitus Type II is a lifelong (chronic) disease in which there is a high level of sugar (glucose) in the blood (https://medlineplus.gov/ency/article/007365.htm).	F 622		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		5/17/19

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F 625	Continued From page 14 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews, and facility documentation, the facility staff failed to issue a written notice of the bed hold policy upon transfer to the local hospital for 7 of 46 residents (R #134, #52, #81, #80, #106, #54 and #50) in the survey sample. 1. The facility staff failed to ensure Resident #134 or Resident Representative (RR) was issued a written notice of the bed hold reserve policy upon	F 625	1. Residents' number #134, #52, #81, #80, #106, #54, and #50 all returned from the Emergency Room or the hospital and therefore no corrective action can be taken with the residents at this time. 2. Residents that transferred to the Emergency Room or were admitted into the hospital in the last 30 days will be reviewed to ensure if the Transfer Summary, which include, the Bed Hold	

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F 625	Continued From page 15 transfer to the local hospital on 3/8/19 and on 3/28/19. 2. The facility staff failed to ensure Resident #52 or RR was issued a written notice of the bed hold policy upon transfer to the local hospital on 2/8/19. 3. The facility staff failed to ensure Resident #81 or RR was issued a written notice of the bed hold policy upon transfer to the local hospital on 3/15/19 and to the emergency department (ED) on 3/20/19. 4. The facility staff failed to ensure Resident #80 or RR was issued a written notice of the bed hold policy upon transfer to the local hospital on 4/6/18 and on 5/22/18. 5. Resident #106 was discharged to the hospital on 01/03/2019 and the facility staff failed to provide the Resident and/or Resident Representative a written Bed Hold Notice. 6. Resident #54 was discharged to the hospital on 04/12/2019 and the facility staff failed to provide the Resident and/or Resident Representative a written Bed Hold Notice. 7. The facility staff failed to ensure that Resident #50 was provided a written copy of the facility's bed-hold and reserve bed payment policy upon transfer/discharge to the hospital on 01/03/19 and 2/3/19. The findings include: 1. The facility staff failed to ensure Resident #134 or Resident Representative (RR) was issued a	F 625	Policy, was sent with the resident. Any variances identified will be corrected. 3. The Director of Nursing/Designee will reeducate RNs and LPNs on the Policy and Procedure of providing the Bed Hold Policy to the resident and documenting in the clinical record the information was conveyed with the resident upon transfer or discharge to the hospital. 4. The Director of Nursing/Designee will review 20% of Emergency Room transfer or hospital discharges for six weeks to ensure the Transfer Summary Report, which contains the Bed Hold Policy, was sent and documented in the nursing notes. The Director of Nursing/Designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly.	

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written notice of the bed hold reserve policy upon transfer to the local hospital on 3/8/19 and on 3/28/19.

Resident #134 was admitted to the nursing facility on 12/5/05 with diagnoses that included adult failure to thrive, fractured right tibia and high blood pressure.

Resident #134's most recent Minimum Data Set (MDS) assessment was a significant change in status assessment dated 3/21/19 and coded the resident with a score of 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was fully intact in the cognitive skills necessary for daily decision making.

The nurse's notes dated 3/8/19 indicated the resident fell on the floor and complained of pain in her right knee. Based on continued complaints of pain, the resident was transported to the ED and admitted to the hospital on 3/8/19. Resident #134 was readmitted to the nursing facility on 3/30/19. There was no documentation in the clinical record that the bed hold notice was issued to the resident or RR at the time of any of the transfers or discharges.

The nurse's notes dated 3/28/19 indicated the transported to the local hospital for surgery. Resident #134 was readmitted to the nursing facility on 3/30/19. There was no documentation in the clinical record that the bed hold notice was issued to the resident or RR at the time of transfer or discharge from the facility.

On 4/18/19 at 1:10 p.m., an interview was conducted with Licensed Practical Nurse (LPN)

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#3. She stated she sent transfer paperwork, but the paperwork did not include a notice of the bed hold reserve policy.

On 4/18/19 at 1:45 p.m., an interview was conducted with Resident #134. The resident stated she was not given any paperwork about the facility's bed hold policy when she was sent out to the hospital.

On 4/18/19 at approximately 5:00 p.m., the Administrator and Director of Nursing (DON) stated "When a resident is transferred to the ER or the hospital the nurse is prompted through a check list in the computer for the specific resident that in turn generates the transfer summary that includes the care plan summary with goals as well as the bed hold notice, but there is no way to confirm the documents was sent at the time of the transfer or that it was sent over to the ED or hospital soon after. We had in-services that instructed the nurse to document in the nurse's notes the summaries and bed hold notices were sent. We actually see some nurses are documenting but others are not and there is a lack of consistency. We will continue to re-educate all our nurses."

The Administrator or DON did not present any additional documentation prior to survey exit on 4/18/19 at 7:00 p.m.

2. The facility staff failed to ensure Resident #52 or RR was issued a written notice of the bed hold policy upon transfer to the local hospital on 2/8/19.

Resident #52 was admitted to the nursing facility on 12/6/17 with diagnoses that included chronic

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kidney disease with hemodialysis, left kidney malignant neoplasm, high blood pressure stroke.

The resident's most recent Minimum Data Set (MDS) assessment was a significant change in status assessment dated 12/17/19 and coded the resident with a score of 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was fully intact in the skills necessary for daily decision making.

The nurse's notes dated 2/8/09 indicated the resident was being sent to the local emergency department (ED) from the dialysis center. The resident returned to the nursing facility on 2/13/19. There was no evidence that the bed hold notice was issued to the resident or the RR at the time of transfer or discharge from the nursing facility.

On 4/18/19 at approximately 5:00 p.m., the Administrator and Director of Nursing (DON) stated that "When a resident is transferred to the ER or the hospital the nurse is prompted through a check list in the computer for the specific resident that in turn generates the transfer summary that includes the care plan summary with goals as well as the bed hold notice, but there is no way to confirm the documents was sent at the time of the transfer or that it was sent over to the ED or hospital soon after. We had in-services that instructed the nurse to document in the nurse's notes the summaries and bed hold notices were sent. We actually see some nurses are documenting but others are not and there is a lack of consistency. We will continue to re-educate all our nurses." They added that they would have to make sure when residents are sent

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to the ED and or admitted to the hospital from a doctors office or dialysis, the transfer summaries are sent over that included the same aforementioned information.

The Administrator or DON did not present any additional documentation prior to survey exit on 4/18/19 at 7:00 p.m.

3. The facility staff failed to ensure Resident #81 or RR was issued a written notice of the bed hold policy upon transfer to the local hospital on 3/15/19 and to the emergency department (ED) on 3/20/19.

Resident #81 was admitted to the nursing facility on 3/1/19 with diagnoses that included stroke, pathological fracture and high blood pressure.

The resident's most recent Minimum Data Set (MDS) assessment was an admission and coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was fully intact in the skills necessary for daily decision making.

The nurse's notes dated 3/15/19 indicated Resident #81 was transferred to the local emergency department and admitted to the hospital for blood in the urine, pain and burning sensation. The resident was readmitted to the nursing facility on 3/16/19. There was no evidence that the bed hold notice was issued to the resident or the RR at the time of transfer from the nursing facility.

The nurse's notes dated 3/20/19 indicated Resident #81 was transferred to the local ED due

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to replacement of indwelling urinary catheter. The resident returned to the nursing facility on 3/20/19. There was no evidence that the bed hold notice was issued to the resident or the RR at the time of transfer from the nursing facility.

On 4/17/19 at 10:10 a.m., Resident #81 was asked if he was issued bed hold reserve policy at the time of any of his transfers or discharges to the local hospital. The resident responded that he was his own power of attorney and would be the one to get any paperwork, but did not believe he was given bed hold notices.

On 4/18/19 at approximately 5:00 p.m., the Administrator and Director of Nursing (DON) stated "When a resident is transferred to the ER or the hospital the nurse is prompted through a check list in the computer for the specific resident that in turn generates the transfer summary that includes the care plan summary with goals as well as the bed hold notice, but there is no way to confirm the documents was sent at the time of the transfer or that it was sent over to the ED or hospital soon after. We had in-services that instructed the nurse to document in the nurse's notes the summaries and bed hold notices were sent. We actually see some nurses are documenting but others are not and there is a lack of consistency. We will continue to re-educate all our nurses." They added that they would have to make sure when residents are sent to the ED and or admitted to the hospital from a doctors office or dialysis, the transfer summaries are sent over that included the same aforementioned information.

The Administrator or DON did not present any additional documentation prior to survey exit on

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4/18/19 at 7:00 p.m.

4. The facility staff failed to ensure Resident #80 or RR was issued a written notice of the bed hold policy upon transfer to the local hospital on 4/6/18 and on 5/22/18.

Resident #80 was admitted to the nursing facility on 3/16/18 with diagnoses that included kidney failure, atrial fibrillation, pressure ulcers, stroke and peripheral vascular disease (PVD).

The resident's most recent Minimum Data Set (MDS) assessment was an admission and coded the resident with a score of 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was fully intact in the skills necessary for daily decision making.

Resident #80 was admitted to the local hospital on 4/6/18 and readmitted to the nursing facility on 4/10/18. There was no evidence that the bed hold notice was issued to the resident or the RR at the time of transfer from the nursing facility.

Resident #80 was admitted to the local hospital on 5/22/19 and readmitted to the nursing facility on 5/29/18. There was no evidence that the bed hold notice was issued to the resident or the RR at the time of transfer from the nursing facility.

On 4/18/19 at approximately 5:00 p.m., the Administrator and Director of Nursing (DON) stated "When a resident is transferred to the ER or the hospital the nurse is prompted through a check list in the computer for the specific resident that in turn generates the transfer summary that includes the care plan summary with goals as

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well as the bed hold notice, but there is no way to confirm the documents was sent at the time of the transfer or that it was sent over to the ED or hospital soon after. We had in-services that instructed the nurse to document in the nurse's notes the summaries and bed hold notices were sent. We actually see some nurses are documenting but others are not and there is a lack of consistency. We will continue to re-educate all our nurses."

The Administrator or DON did not present any additional documentation prior to survey exit on 4/18/19 at 7:00 p.m.

5. Resident #106 was discharged to the hospital on 01/03/2019 and the facility staff failed to provide the Resident and/or Resident Representative a written Bed Hold Notice.

Resident #106 was discharged to the hospital on 01/03/2019 and readmitted to the facility on 01/08/2019. Diagnosis included but were not limited to, Multiple Sclerosis, Quadriplegia and Hypertension.

Resident #106's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 03/23/2019 coded Resident #106 with a BIMS (Brief Interview for Mental Status) score of 14 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #106 as requiring total assistance with Activities of Daily Living.

On 04/18/2019 at 5:20 p.m., an interview was conducted with the Director of Nursing (DON). The DON was asked, "Can you provide documentation that a Bed Hold Notice was issued

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to Resident #106 or the resident's representative upon discharge to the hospital?" The DON stated, "No, there is no documentation to support that it was provided." The DON stated, "Nursing usually sends a Transfer Clinical Summary with residents when transferring to the hospital which includes the care plan and Bed Hold Notice. However, there is no documentation stating that it was sent."

The administrative team was informed of the finding on 04/18/2019 at approximately 6:30 p.m. No further information was provided about the finding.

6. Resident #54 was discharged to the hospital on 04/12/2019 and the facility staff failed to provide the Resident and/or Resident Representative a written Bed Hold Notice.

Resident #54 was discharged to the hospital on 04/12/2019 and readmitted to the facility on 04/15/2019. Diagnosis included but were not limited to, Heart Failure and Diabetes Mellitus.

Resident #54's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 02/18/2019 coded Resident #54 with a BIMS (Brief Interview for Mental Status) score of 4 indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #54 as requiring extensive assistance of 2 with bed mobility, extensive assistance of 1 with eating and personal hygiene, and total dependence of 2 with transfer and toilet use.

On 04/18/2019 at 5:20 p.m., an interview was

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conducted with the Director of Nursing (DON) and he was asked, "Can you provide documentation that a Bed Hold Notice was issued to Resident #54 or the Resident's Representative upon discharge to the hospital?" The DON stated, "No, there is no documentation." The DON was asked, "Was a Bed hold Notice issued to Resident #54 or the Resident's Representative upon discharge to the hospital?" The DON stated, "No, it was not." The DON was asked, "Should a written Bed Hold Notice be issued to the Resident and /or Resident Representative upon discharge?" The DON stated, "Yes."

On 04/19/2019 at approximately 6:30 p.m., at the pre-exit meeting the Administrator and the Director of Nursing was informed of the findings. The facility did not present any further information about the findings.

7. The facility staff failed to ensure that Resident #50 was provided a written copy of the facility's bed-hold and reserve bed payment policy upon transfer/discharge to the hospital on 01/03/19 and 2/3/19.

Resident #50 was originally admitted to the facility on 12/05/13. The resident was re-admitted on 11/29/18 and 01/08/19. Diagnosis for Resident #50 included but not limited to *Dementia and *Type II Diabetes.

Resident #50's current Minimum Data Set (MDS), a significant change with an Assessment Reference Date (ARD) of 02/14/19 coded the resident with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions.

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The Discharge MDS assessment dated 11/25/18-discharge return anticipated, resident re-admitted on 11/29/18.

The Discharge MDS assessment dated 01/03/19-discharge return anticipated, resident re-admitted on 01/08/19.

On 11/25/18 at approximately 3:31 a.m., according to the facility's documentation, "Per order from the on call Physician Assistant (PA), new order obtained to send Resident #50 to the local Emergency Room (ER) for a critical lab Sodium level of 169." Resident #50 was re-admitted to the nursing facility on 11/29/18.

On 01/03/19 at approximately 3:03 p.m., according to the facility's documentation, "Nurse Practitioner (NP) in to assess resident with new orders to send to local ER after speaking to daughter to see what she decides." The daughter wanted to send Resident #50 to the ER. The daughter has declined hospice at this time. The resident was transported to the local ER via (Name of Company) transportation. Resident #50 was re-admitted to the nursing facility on 01/08/19.

An interview was conducted with the Administrator and Director of Nursing (DON) on 04/18/19 at approximately 5:00 p.m. The DON said he was unable to locate documentation in Resident #50's clinical record that the bed hold policy was sent when discharged to the hospital on 11/25/18 and 01/03/19. The DON said when a resident is transferred to the hospital; the nurse will complete a checklist in the computer that will prompt the nurse to check the bed hold policy notice for that resident. The checklist is

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converted into a Transfer Clinical Summary. The Transfer Clinical Summary if completed correctly will include the bed hold policy notice but the nurses must document the bed hold policy was sent when discharged to the hospital in their clinical record. The DON stated, "Since, we were unable to locate documentation in Resident #50's clinical record, I cannot say the bed hold policy was sent with Resident #50 when discharged to the hospital on 11/25/18 and 01/03/19."

The facility administration was informed of the finding during a briefing on 04/18/19 at approximately 6:25 p.m. The facility did not present any further information about the findings.

The facility's policy titled Admission, Transfer & Discharge Right Policy revised (01/25/17). Notice of bed-hold policy and return. If a resident requires transfer to an acute hospital, the facility will offer the resident the opportunity of electing to have the bed held.

Definitions:

*Dementia is the name for a group of symptoms caused by disorders that affect the brain. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there (https://medlineplus.gov/ency/article/007365.htm).

*Diabetes Mellitus Type II is a lifelong (chronic) disease in which there is a high level of sugar (glucose) in the blood (https://medlineplus.gov/ency/article/007365.htm).

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F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility documentation the facility staff failed to assure that 1 of 46 residents (Resident #84) in the survey sample received a complete and accurate assessment. The facility staff failed to ensure the MDS with an Assessment Reference Date (ARD) of 03/08/19 under Section N (Medications) for the use of an antipsychotic medication (Seroquel) was coded correctly for Resident #84. The findings included: Resident #84 was admitted to the facility 3/01/19. Diagnosis for Resident #84 included but not limited to *Vascular Dementia with behavior disturbances. Resident #84's quarterly MDS with an Assessment Reference Date (ARD) of 03/08/19 coded resident with a BIMS score of 02 out of a possible 15 indicating severe cognitive impairment. Review of Resident #84's quarterly MDS with an ARD of 03/08/19 was coded one (1) for receiving Antipsychotic medications. Section N on the MDS under medications received read as follows: Indicate the number of DAYS the resident receiving the medication during the last 7 days, enter "0" if medication was not received by the	F 641	1. The MDS with the ARD of 03/08/19 for resident #84 was modified to reflect accurate coding for section N for the use of an antipsychotic medication. The modified MDS was transmitted to CMS. The Resident Assessment Coordinators were reeducated on the importance of accurate completion of MDS regarding antipsychotic medications. 2. The Assistant Director of Nursing/Designee will review all MDSs completed for the past 30 days to ensure accuracy of section N. Any variances identified will be corrected in accordance with the RAI manual. MDS staff will be responsible for ensuring accurate coding on all MDS assessments. 3. The Director of Nursing/Designee will in-service MDS coordinators on the importance of coding accuracy according to the RAI manual. The education will include, but is not limited to, a review of the RAI manual instruction for Section N and antipsychotic medications. 4. The Assistant Director of Nursing/Designee will review 20% of MDSs completed weekly for six weeks to ensure accurate coding of section N for antipsychotic medications. The Director of Nursing/Designee will identify any patterns or trends and report to the Quality Assurance and Performance	5/17/19

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F 641	Continued From page 28 resident during the last 7 days. Resident #84's comprehensive care plan documented resident at risk for side effects related to use of psychoactive medications. Some of the goals set for the resident included not but not limited to: will achieve desired effect from ordered medications, and will have no negative effects from medication use as ordered. Some of the intervention to manage the resident's goal include observing and reporting signs/symptoms of tardive dyskinesia, complete AIMS per facility policy, consult, and coordinate care with mental health professional per physician order. The physician order reads: Starting on 03/01/19-*Seroquel 25 mg tablet-give 1 tablet by mouth at bedtime for five days (psychotic disorder with delusions). Review of Resident #84's March 2019 Medication Administration Record (MAR) revealed the medication Seroquel was administered three times for the look back period of 7 days for the MDS with an ARD date of 03/08/19. An interview was conducted with MDS Coordinator on 4/18/19 at approximately 5:22 p.m. She compared the March 2019, MAR with the MDS with an ARD date of 03/08/19 under section N, and then stated, "The MDS should have been coded (3) for the amount of times administered." The surveyor asked, "Is this an accurate MDS" she replied, "No, not for this assessment." The facility administration was informed of the finding during a briefing on 04/18/19 at	F 641	Improvement Committee at least quarterly.	

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approximately 5:25 p.m. The facility did not present any further information about the findings.

CMS's RAI Version 3.0 Manual (Chapter 1: Resident assessment Instrument (RAI)

1). 1.3 Completion of the RAI (1) the assessment accurately reflects the resident's status.

Goals: The goal of the MDS 3.0 revision are to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, increase the resident's voice by introducing more resident interview items. Providers, consumers, and other technical experts in the nursing home care requested that MDS 3.0 revision focus on improving the tool's clinical utility, clarity, and accuracy.

Definitions:

*Seroquel tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods) ((https://medlineplus.gov/ency/article/007365.htm).

*Vascular dementia is a general term describing problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain (https://www.mayoclinic.org/diseases-conditions/vascular-dementia/symptoms).

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F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions.	F 655		5/17/19

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F 655	Continued From page 31 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff and resident interview and facility document review, the facility staff failed to ensure a person-centered baseline care plan was developed within 48 hours of admission that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 of 46 residents (Resident #440) in the survey sample. Resident #440, a newly admitted stroke resident, had difficulty at times communicating her needs to the nursing staff (expressive aphasia). The facility staff failed to ensure communication needs were included in the 48 hour baseline care plan. This failure resulted in resident frustration during episodes of her inability to communicate verbally or through gestures. The findings included: Resident #440 was admitted to the nursing facility on 4/12/19 with a diagnosis of atrial fibrillation and history of cerebral infarction (stroke) with left sided hemiplegia. The resident's Minimum Data Set (MDS) assessment was not due. The 48 hour baseline care plan dated 4/12/19-4/14/19 identified the resident had the	F 655	1. The baseline care plan for resident #440 was updated and provides instructions needed to ensure effective person centered care including communication needs. 2. The Director of Nursing/ designee has reviewed the baseline care plans of all newly admitted residents for whom the comprehensive care plan has not yet been created. The review was to ensure baseline care plans include the instructions needed to provide effective person centered care for communication needs. Baseline care plans were updated as needed. 3. The Director of Education/designee will reeducate RNs and LPNs on Development and Implementation of Baseline Care Plans. The in-service will include, but not limited to, a review of the baseline care plan creation process and assessment of residents' individual needs. The care plan should also include instructions to ensure the delivery of effective person centered care with special focus on communication needs. 4. The Director of Nursing/designee will review the baseline care plans of all newly admitted residents weekly for six weeks. The review will ensure baseline care plans include the instructions needed to provide effective person centered care for	

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F 655	Continued From page 32 potential for impaired quality of life related to a new environment and change in health status. The goal set by the staff for the resident indicated that the resident would not experience adverse effects for new admission or new environment. There were no approaches that addressed the resident's difficulty in communication in order to create and maintain a safe environment and psychological well-being. The care plan did not identify the stroke and any deficits she had as a result of past or current stroke with staff interventions and/or resident needs. The following observation was made of Resident #440 on 4/17/19 at 12:10 p.m.: Resident #440 was positioned in the doorway of her room in her wheelchair. She summoned the Certified Nursing Assistant (CNA) #1 and asked her what sounded like "a couple of pictures." When the CNA could not understand her after several attempts, a second and third staff approached the resident due to the resident's obvious distress. These persons were not able to understand the resident as she kept repeating the same phrase over and over "a couple of pictures." The Unit Manager, Licensed Practical Nurse (LPN) #3 asked the resident several times to tell her what she wanted and the same phrase was repeated by the resident. The resident began stomping her feet, shaking her head from sided to side, hitting herself violently and screaming as loud as she could as she cried with tears streaming down her face. Three more times the CNA, Unit Manager and others surrounded the resident asking her what she wanted to no avail. CNA #1 pulled the resident into her room as the resident continued the same aforementioned behavior. The resident pointed to this surveyor	F 655	communication needs. The Director of Nursing/Designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly.	

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with her right hand and motioned to come to her. Once the resident was approached she appeared to want what this surveyor was holding, a clip board, but no one was sure why. This surveyor asked the group, "Does she use a communication board?" The Unit Manager ran to the nurse's station and returned approximately 5 minutes later with a communication sheet and pointed to several pictured items and letters, but the resident continued with her frustrated behavior. The resident motioned again to this surveyor. The question was asked at this point, "Does she write?" One of the staff present retrieved a blank sheet of paper, gave it to her with a pen as the resident tried to write in cursive with the paper on her left thigh. No one could read the message the resident tried to write. Due to the resident's continued behaviors of screaming, crying, stomping and slapping herself, this surveyor came closer to the resident. The resident took the clipboard placed the paper on the clipboard and was prompted to print what she was trying to tell the staff. The resident printed very clearly, "cowboy picture" pointing to the television. CNA #1 immediately said, "She wants the television channel to remain on the channel that has cowboys on it." As quickly as the extreme outburst began, it ended and the resident rose her right hand to high five everyone with smiles. CNA #1 said, "Oh that's right, her daughter wrote it on a piece of paper and told us to keep the channel on 75 which is a cowboy channel."

On 4/18/19 at 10:30 a.m., an interview was conducted with the speech therapist (ST). She stated the resident was screened and assessed on 4/15/19 with a new stroke, but had a history of previous stroke with some expressive aphasia

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per information from the resident's daughter. The ST stated she thought the most recent stroke resulted in left sided weakness. The ST evaluation dated 4/15/19 indicated the resident had severe impairment in articulation with moderate intelligibility, but the fluency was within normal limits meaning that she could put several words together. When the episode from 4/17/19 at 12:10 p.m. was explained to the ST, she stated the goal was to increase articulation, but when all else fails and the resident becomes frustrated, a pen and pad of paper was necessary in order to reduce frustration and have her needs met, as well as a communication board. When asked where this information was written because it was not in the ST screening evaluation, or how the information was relayed to the nursing staff she said, "That is not what I do, the rehabilitation director would share that information with the nursing staff."

On 4/18/19 at 12:15 p.m., the rehabilitation director stated the ST should have shared what the resident needed to communicate with the nursing staff in order to have her needs met. She also said during the morning meetings especially on the skilled unit where the resident resided results of screenings and evaluations are shared with nurse managers and the MDS nurse, along with reading the therapy notes, thus the care plan would reveal the need with goals and interventions. The ST stated it was her expectation that once the evaluation is completed, the charge nurse, therapy head and Director of Nursing (DON) be made aware of what is needed for patients care; in this case a communication board, paper and pen if able to write to avoid times of frustration when the resident cannot verbally communicate her needs.

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She stated once everything is completed, nursing will update the care plan. She presented a re-evaluation 4/18/19 at 3:15 p.m. that was conducted shortly after this interview that educated the resident on strategies on how to slow her speech rate, increase intensity and over exaggerate sounds to increase speech intelligibility. The evaluation included provision of communication board, pad and pen to increase communication wants and needs and that this was an alternative means to communication in case of communication breakdown.

On 4/18/19 at approximately 5:00 p.m., an interview was conducted with the Administrator, the DON and the Assistant Director of Nursing Operations (ADNO). The DON stated even without any information from ST, he expected the nursing staff to have been able to handle the aforementioned situation and provide the resident with either a communication tool or pad and pencil. The Administrator stated, "I think that situation could have definitely been handled better for the resident's sake as well as safety."

During the debriefing with the Administrator, DON and ADNO on 4/18/19 at approximately 6:00 p.m., no further information was provided prior to survey exit.

The policy and procedures titled "Person-centered Baseline and Comprehensive Care Plan" dated 5/17/18 indicated all residents should have a person-centered baseline care plan developed within 48 hours of admission by the interdisciplinary team. The baseline care plan must address medical, nursing, mental, and psychosocial needs to include personal and cultural preferences. The baseline care plan

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F 655	Continued From page 36 must include, but is not limited to initial goals based on admission, physician orders, dietary orders, therapy services, social services, PASRR recommendations if appropriate.	F 655		
F 675 SS=D	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff and resident interview and facility document review, the facility staff failed to ensure the necessary person-centered care and services were provided for 1 of 46 residents (Resident #440) in the survey sample. Resident #440, a newly admitted stroke resident, had difficulty at times communicating her needs to the nursing staff (expressive aphasia). The facility staff failed to have the appropriate communication devices as needed when the resident was unable to verbally find the right words or gesture to enable the staff to understand her, which caused her extreme distress and frustration. The findings included:	F 675	1. Resident #440 was assessed for communication needs and appropriate communication device has been provided. 2. The Director of Nursing/ designee has conducted an assessment of current residents with expressive aphasia to ensure their communication needs are met. Appropriate communication devices have been provided to residents as needed. 3. The Director of Education/designee has reeducated RNs and LPNs on Assessing Resident□s Needs for Communication Devices. The in-service included, but was not limited to, the importance of appropriate assessment and identification of communication needs. 4. The Director of Nursing /designee will	5/17/19

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F 675	Continued From page 37 Resident #440 was admitted to the nursing facility on 4/12/19 with a diagnosis of atrial fibrillation and history of cerebral infarction (stroke) with left sided hemiplegia. The resident's Minimum Data Set (MDS) assessment was not due. The 48 hour baseline care plan dated 4/12/19-4/14/19 identified the resident had the potential for impaired quality of life related to a new environment and change in health status. The goal set by the staff for the resident indicated that the resident would not experience adverse effects for new admission or new environment. There were no approaches that addressed the resident's difficulty in communication in order to create and maintain a safe environment and psychological well-being. The care plan did not identify the stroke and any deficits she had as a result of past or current stroke with staff interventions and/or resident needs. The following observation was made of Resident #440 on 4/17/19 at 12:10 p.m.: Resident #440 was positioned in the doorway of her room in her wheelchair. She summoned the Certified Nursing Assistant (CNA) #1 and asked her what sounded like "a couple of pictures." When the CNA could not understand her after several attempts, a second and third staff approached the resident due to the residents obvious distress. These persons were not able to understand the resident as she kept repeating the same phrase over and over "a couple of pictures." The Unit Manager, Licensed Practical Nurse (LPN) #3 asked the resident several times to tell her what she wanted and the same phrase	F 675	perform weekly audits for six weeks of all newly admitted residents to ensure that each resident□s individual communication needs are assessed, and the appropriate communication devices are provided if needed. The Director of Nursing/Designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly.	

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was repeated by the resident. The resident began stomping her feet, shaking her head from sided to side, hitting herself violently and screaming as loud as she could as she cried with tears streaming down her face. Three more times the CNA, Unit Manager and others surrounded the resident asking her what she wanted to no avail. CNA #1 pulled the resident into her room as the resident continued the same aforementioned behavior. The resident pointed to this surveyor with her right hand and motioned to come to her. Once the resident was approached she appeared to want what this surveyor was holding, a clip board, but no one was sure why. This surveyor asked the group, "Does she use a communication board?" The Unit Manager ran to the nurse's station and returned approximately 5 minutes later with a communication sheet and pointed to several pictured items and letters, but the resident continued with her frustrated behavior. The resident motioned again to this surveyor. The question was asked at this point, "Does she write?" One of the staff present retrieved a blank sheet of paper, gave it to her with a pen as the resident tried to write in cursive with the paper on her left thigh. No one could read the message the resident tried to write. Due to the resident's continued behaviors of screaming, crying, stomping and slapping herself, this surveyor came closer to the resident. The resident took the clipboard placed the paper on the clipboard and was prompted to print what she was trying to tell the staff. The resident printed very clearly, "cowboy picture" pointing to the television. CNA #1 immediately said, "She wants the television channel to remain on the channel that has cowboys on it." As quickly as the extreme outburst began, it ended and the resident rose her right hand to high five everyone

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with smiles. CNA #1 said, "Oh that's right, her daughter wrote it on a piece of paper and told us to keep the channel on 75 which is a cowboy channel."

On 4/18/19 at 10:30 a.m., an interview was conducted with the speech therapist (ST). She stated the resident was screened and assessed on 4/15/19 with a new stroke, but had a history of previous stroke with some expressive aphasia per information from the resident's daughter. The ST stated she thought the most recent stroke resulted in left sided weakness. The ST evaluation dated 4/15/19 indicated the resident had severe impairment in articulation with moderate intelligibility, but the fluency was within normal limits meaning that she could put several words together. When the episode from 4/17/19 at 12:10 p.m. was explained to the ST, she stated the goal was to increase articulation, but when all else fails and the resident becomes frustrated, a pen and pad of paper was necessary in order to reduce frustration and have her needs met, as well as a communication board. When asked where this information was written because it was not in the ST screening evaluation, or how the information was relayed to the nursing staff she said, "That is not what I do, the rehabilitation director would share that information with the nursing staff."

On 4/18/19 at 12:15 p.m., the rehabilitation director stated the ST should have shared what the resident needed to communicate with the nursing staff in order to have her needs met. She also said during the morning meetings especially on the skilled unit where the resident resided results of screenings and evaluations are shared with nurse managers and the MDS nurse, along

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with reading the therapy notes, thus the care plan would reveal the need with goals and interventions. The ST stated it was her expectation that once the evaluation is completed, the charge nurse, therapy head and Director of Nursing (DON) be made aware of what is needed for patients care; in this case a communication board, paper and pen if able to write to avoid times of frustration when the resident cannot verbally communicate her needs. She stated once everything is completed, nursing will update the care plan. She presented a re-evaluation 4/18/19 at 3:15 p.m. that was conducted shortly after this interview that educated the resident on strategies on how to slow her speech rate, increase intensity and over exaggerate sounds to increase speech intelligibility. The evaluation included provision of communication board, pad and pen to increase communication wants and needs and that this was an alternative means to communication in case of communication breakdown.

On 4/18/19 at approximately 5:00 p.m., an interview was conducted with the Administrator, the DON and the Assistant Director of Nursing Operations (ADNO). The DON stated even without any information from ST, he expected the nursing staff to have been able to handle the aforementioned situation and provide the resident with either a communication tool or pad and pencil. The Administrator stated, "I think that situation could have definitely been handled better for the resident's sake as well as safety."

During the debriefing with the Administrator, DON and ADNO on 4/18/19 at approximately 6:00 p.m., no further information was provided prior to survey exit.

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F 675	Continued From page 41 The policy and procedures titled "Providing Auxiliary Aids for Persons with Disabilities" dated 1/30/13 indicated the necessary provisions to ensure effective communication. Residents would be evaluated to identify is there would be a benefit from auxiliary aides and services. Facility staff would assist those residents with speech impairments in obtaining the necessary services to ensure they are able to achieve effective communication. These services may include, but are not limited to: computer, typewriter, flashcards, alphabet boards, communication boards, telecommunication devices, notepad, etc.	F 675		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		5/17/19

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F 758	Continued From page 42 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility documentation, the facility staff failed to ensure a PRN (as needed) psychotropic medication (Ativan) order was limited to 14 days and failed to re-evaluate the resident for appropriateness of the medication for one resident (Resident #84) of 46 residents in the survey sample who was receiving a PRN (as needed) psychotropic medication. The facility staff failed to ensure a PRN (as needed) psychotropic medication (Ativan) order	F 758	1. Resident #84 has been reevaluated by the physician and the PRN psychotropic medication has been discontinued. 2. The Director of Nursing/ designee has performed an audit of all residents receiving PRN psychotropic medications to ensure the 14-day stop date has been followed or the physician has documented rationale for continuance past 14 days. The physician was made aware of any orders lacking the required stop date or	

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was limited to 14 days. The physician did not do an evaluation of Resident #84 to extend the psychotropic medication passed 14 days and did not document the rational and duration in the resident's medical record.

The findings included:

Resident #84 was admitted to the facility 3/01/19. Diagnosis for Resident #84 included but not limited to *Vascular Dementia with behavior disturbances. Resident #84's MDS with an Assessment Reference Date (ARD) of 03/08/19 coded resident with a BIMS score of 02 out of a possible 15 indicating severe cognitive impairment.

In addition, the MDS with an ARD of 03/08/19, under section "E" (Behaviors), coded Resident #84 for exhibiting physical and verbal behaviors directed towards others 1-3 days each week. The resident was also coded for other behaviors symptoms not directed toward others. Under section (E0800), for rejection of care was coded the behavior occurred 1-3 days each week and under section (E0900), for wandering was coded for this type behavior occurring daily.

Resident #84's comprehensive care plan documented resident at risk for side effects related to use of psychoactive medications. Some of the goals set for the resident included not but not limited to: will achieve desired effect from ordered medications, and will have no negative effects from medication use as ordered. Some of the intervention to manage the resident's goal include observing and reporting signs/symptoms of tardive dyskinesia, complete AIMS per facility policy, consult and coordinate

required physicians' documentation and the orders were updated as directed by the physician.
3. The Director of Education/designee has reeducated RNs and LPNs on PRN Psychotropic Medications. The in-service included, but was not limited to, re-educating nurses on identifying psychotropic medication orders and ensuring the physician has documented rational for continuing the medication past 14 days.
4. The Director of Nursing/designee will perform weekly audits for six weeks of all residents with PRN psychotropic medication orders to ensure that each order has an appropriate stop date or the physician has documented rationale for continuance past 14 days. The Director of Nursing/designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly.

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care with mental health professional per physician order and Consulting Pharmacist Medication Regimen Review at least monthly.

The physician Order Sheet (POS) for April 2019 included the following orders:

1. Ativan 0.5 mg tablet by mouth as needed every 8 hours starting on 03/03/19 for the following target behaviors: inconsolable restlessness, physically abusive, agitation, combativeness and delusion.

2. Ativan 2 mg/ml injection solution-give 0.5 ml intramuscular as need every 6 hours if unable to take by mouth or sublingual starting on 03/08/19 for the following target behaviors: inconsolable restlessness, physically abusive, agitation, combativeness and delusion.

The March 2019 Medication Administration Records (MAR's) evidenced documentation that the resident was administered the PRN Ativan 0.5 mg by mouth on the following days: 03/22/19 at 11:18 a.m., 03/28/19 at 10:34 p.m., and 03/29/19 at 11:43 p.m.

The April 2019 Medication Administration Records (MAR's) evidenced documentation that the resident was administered the PRN Ativan 0.5 ml (IM) on 03/27/19 at 9:25 p.m.

Review of Resident #84's Physician Progress note dated 03/26/19 include the following:
-Nature of Presenting Problem: First 30-day recertification and review of chronic illness and comorbidity.
-History of Present Illness include but not limited to resident has dementia with history of behaviors

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that include combativeness. No recent behaviors note since last exam.
-All medications reviewed during today's visit.
The physician last saw resident #84 on 03/18/19 prior to his current visit on 03/26/19.

An interview was conducted with the Director of Nursing (DON) on 04/18/19 at approximately 4:55 p.m. The DON stated, "I was aware the PRN antipsychotic medication was good for only 14 days then must be re-evaluated but not the psychotropic." He said the PRN psychotropic are not being re-evaluated after 14 days.

The facility administration was informed of the finding during a briefing on 04/18/19 at approximately 5:25 p.m. The facility did not present any further information about the findings.

The facility policy titled Virginia Health Services (VHS) Standing Orders (Revised on 12/15/17) did not include antipsychotropic medications prescribed on a PRN basis are limited to 14 days without documenting the rational and duration on the residents medical record.

Definitions:
*Vascular dementia is a general term describing problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain (https://www.mayoclinic.org/diseases-conditions/vascular-dementia/symptoms).

*Ativan is used to relieve anxiety (www.nlm.nih.gov/medlineplus/druginfo/meds/a682053.html).

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F 761	Continued From page 46	F 761		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on general observation of the nursing facility, staff interviews, the facility failed to ensure medications were stored in accordance with currently accepted professional principles in 1 out of 9 facility medication carts. The facility staff failed to ensure one eye drop (Latanoprost) was removed from medication cart once expired on Unit (M). The eye drops in its	F 761	1. The eye drop, Latanoprost, was discarded, according to the facility medication destruction policy on April 18, 2019. The staff were reeducated on the requirement of disposing of medication after the use by date. 2. The Director of Nursing/designee has performed inspection of all medication carts, refrigerators, and medication rooms	5/17/19

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F 761	Continued From page 47 original box had an open date of 03/04/19 with a do not use date after 04/04/19. The findings included: Resident #41 was originally admitted to the facility on 11/27/09. Diagnosis for Resident #41 included but not limited to *Glaucoma. Resident #41's Minimum Data Set (an assessment protocol) with an Assessment Reference Date (ARD) of 02/07/19 coded Resident #41 with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. On 04/18/19 at approximately 1:35 p.m., the medication cart on Unit (M) with License Practical Nurse (LPN) #2 was inspected. During the inspection of the medication cart the eye drops (Lantanoprost) was observed in the cart. The eye drops were stored in its original box. Written on the box was an open date of 03/04/19 with a do not use after 04/04/19. The surveyor asked LPN #2, "How long is the eye drop (Latanoprost solution 0.005%) good for once opened." The LPN stated, "It is good for 30 after being open." The surveyor asked, "Should the eye drops still be stored inside the medication cart after the expiration time has lapsed" she replied, "Absolutely not, it should not be on the medication cart past 30 days after being opened." The LPN said the eye drops should have been removed the medication cart on 04/04/19. An interview was conducted with the Director of Nursing (DON) on 04/18/19 at approximately 5:02 p.m. The DON stated, "All the nurses should be doing the 5 rights prior to administering a resident their medication." The DON said the charge	F 761	to ensure all medications have been dated appropriately and discarded upon their expiration and/or use by date. 3. The Director of Education/designee has reeducated RNs and LPNs on Labeling and Storage of Drugs and Biologicals. The in-service included, but was not limited to, a review of the facility's policy Storage and Expiration Dating of Medications, as well as, the protocol for discarding medications. 4. The Director of Nursing/designee will perform weekly inspections for six weeks of the medication refrigerators, medication cart, treatment carts, and medication storage areas to ensure all medications are dated when opened and have not expired. The Director of Nursing/designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly.	

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nurse should be inspecting the medication cart daily behind the floor nurses as a double check. He said the charge nurse should catch any expired medications left on the medication cart.

The facility administration was informed of the finding during a briefing on 04/18/19 at approximately 6:25 p.m. The facility did not present any further information about the findings.

The facility's policy titled Medication Administration Guidelines (Revision date 09/08/17).

-Medication Administration read in part: Prior to administration, the medication and dosage schedule on the MAR/TAR is compared with the medication label. If the medication is discontinued, outdated, or unusable, remove the medication for proper disposal.

*How to store Latanoprost: After opening the bottle store it at room temperature (do not store above 25°C) and use within 4 weeks of opening. When you are not using Latanoprost, keep the bottle in the outer carton, in order to protect it from light (www.drugs.com).

Definitions:

*Latanoprost is used to treat high pressure inside the eye due to glaucoma (open angle type) or other eye diseases (e.g., ocular hypertension) (https://www.webmd.com/drugs).

*Glaucoma is an eye disease associated with increased pressure within the eye. Glaucoma can damage the optic nerve and cause impaired vision and blindness

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F 761	Continued From page 49 (https://www.webmd.com/drugs).	F 761		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff and resident interview and facility document review, the facility staff failed to ensure the specialized rehabilitation services were provided for 1 of 46 residents (Resident #440) in the survey sample. Resident #440, a newly admitted stroke resident, had difficulty at times communicating her needs to the nursing staff (expressive aphasia). The facility staff failed to ensure speech therapy recommended the appropriate communication	F 825	1. The Speech Therapist has reassessed resident #440 for communication needs and a pad and writing device was made available to the resident for times when the resident has difficulty expressing needs to nursing staff. 2. The Director of Clinical Operations for Therapy Services/designee has performed an audit of all residents on speech therapy case load to ensure their communication needs are met and an	5/17/19

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	495286	A. BUILDING _____ B. WING _____	C 04/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES RIVER CONVALESCENT CENTE	540 ABERTHAW AVENUE NEWPORT NEWS, VA 23601

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F 825	Continued From page 50 devices as needed and relayed information to the nursing staff. Failure to take these steps resulted in the nursing staff's failure to provide alternate communication devices to foster appropriate communication to and from the resident in order to avoid episodes of distress and frustration. The findings included: Resident #440 was admitted to the nursing facility on 4/12/19 with a diagnosis of atrial fibrillation and history of cerebral infarction (stroke) with left sided hemiplegia. The resident's Minimum Data Set (MDS) assessment was not due. The 48 hour baseline care plan dated 4/12/19-4/14/19 identified the resident had the potential for impaired quality of life related to a new environment and change in health status. The goal set by the staff for the resident indicated that the resident would not experience adverse effects for new admission or new environment. There were no approaches that addressed the resident's difficulty in communication in order to create and maintain a safe environment and psychological well-being. The care plan did not identify the stroke and any deficits she had as a result of past or current stroke with staff interventions and/or resident needs. The following observation was made of Resident #440 on 4/17/19 at 12:10 p.m.: Resident #440 was positioned in the doorway of her room in her wheelchair. She summoned the Certified Nursing Assistant (CNA) #1 and asked her what sounded like "a couple of pictures."	F 825	appropriate communication device is provided to the resident if needed. 3. The Director of Clinical Operations for Therapy Services/designee has reeducated Speech Therapists on Assessing Residents Needs for Appropriate Communication Devices. The in-service included but was not limited to identification and assessment of residents with episodic communication needs and conveying the findings to nursing. 4. The Director of Clinical Operations for Therapy Services/designee will perform weekly audits for six weeks of all residents on speech therapy's case load to ensure each resident's individual communication needs are assessed, and if needed the appropriate communication devices are provided. The Director of Clinical Operations for Therapy Services/designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly.	

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When the CNA could not understand her after several attempts, a second and third staff approached the resident due to the residents obvious distress. These persons were not able to understand the resident as she kept repeating the same phrase over and over "a couple of pictures." The Unit Manager, Licensed Practical Nurse (LPN) #3 asked the resident several times to tell her what she wanted and the same phrase was repeated by the resident. The resident began stomping her feet, shaking her head from sided to side, hitting herself violently and screaming as loud as she could as she cried with tears streaming down her face. Three more times the CNA, Unit Manager and others surrounded the resident asking her what she wanted to no avail. CNA #1 pulled the resident into her room as the resident continued the same aforementioned behavior. The resident pointed to this surveyor with her right hand and motioned to come to her. Once the resident was approached she appeared to want what this surveyor was holding, a clip board, but no one was sure why. This surveyor asked the group, "Does she use a communication board?" The Unit Manager literally ran to the nurse's station and returned approximately 5 minutes later with a communication sheet and pointed to several pictured items and letters, but the resident continued with her frustrated behavior. The resident motioned again to this surveyor. The question was asked at this point, "Does she write?" One of the staff present retrieved a blank sheet of paper, gave it to her with a pen as the resident tried to write in cursive with the paper on her left thigh. No one could read the message the resident tried to write. Due to the resident's continued behaviors of screaming, crying, stomping and slapping herself, this surveyor

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came closer to the resident. The resident took the clipboard placed the paper on the clipboard and was prompted to print what she was trying to tell the staff. The resident printed very clearly, "cowboy picture" pointing to the television. CNA #1 immediately said, "She wants the television channel to remain on the channel that has cowboys on it." As quickly as the extreme outburst began, it ended and the resident rose her right hand to high five everyone with smiles. CNA #1 said, "Oh that's right, her daughter wrote it on a piece of paper and told us to keep the channel on 75 which is a cowboy channel."

On 4/18/19 at 10:30 a.m., an interview was conducted with the speech therapist (ST). She stated the resident was screened and assessed on 4/15/19 with a new stroke, but had a history of previous stroke with some expressive aphasia per information from the resident's daughter. The ST stated she thought the most recent stroke resulted in left sided weakness. The ST evaluation dated 4/15/19 indicated the resident had severe impairment in articulation with moderate intelligibility, but the fluency was within normal limits meaning that she could put several words together. When the episode from 4/17/19 at 12:10 p.m. was explained to the ST, she stated the goal was to increase articulation, but when all else fails and the resident becomes frustrated, a pen and pad of paper was necessary in order to reduce frustration and have her needs met, as well as a communication board. When asked where this information was written because it was not in the ST screening evaluation, or how the information was relayed to the nursing staff she said, "That is not what I do, the rehabilitation director would share that information with the nursing staff."

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F 825	Continued From page 53	F 825		

On 4/18/19 at 12:15 p.m., the rehabilitation director stated the ST should have shared what the resident needed to communicate with the nursing staff in order to have her needs met. She also said during the morning meetings especially on the skilled unit where the resident resided results of screenings and evaluations are shared with nurse managers and the MDS nurse, along with reading the therapy notes, thus the care plan would reveal the need with goals and interventions. The ST stated it was her expectation that once the evaluation is completed, the charge nurse, therapy head and Director of Nursing (DON) be made aware of what is needed for patients care; in this case a communication board, paper and pen if able to write to avoid times of frustration when the resident cannot verbally communicate her needs. She stated once everything is completed, nursing will update the care plan. She presented a re-evaluation 4/18/19 at 3:15 p.m. that was conducted shortly after this interview that educated the resident on strategies on how to slow her speech rate, increase intensity and over exaggerate sounds to increase speech intelligibility. The evaluation included provision of communication board, pad and pen to increase communication wants and needs and that this was an alternative means to communication in case of communication breakdown.

On 4/18/19 at approximately 5:00 p.m., an interview was conducted with the Administrator, the DON and the Assistant Director of Nursing Operations (ADNO). The DON stated even without any information from ST, he expected the nursing staff to have been able to handle the aforementioned situation and provide the resident

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F 825	Continued From page 54 with either a communication tool or pad and pencil. The Administrator stated, "I think that situation could have definitely been handled better for the resident's sake as well as safety." During the debriefing with the Administrator, DON and ADNO on 4/18/19 at approximately 6:00 p.m., no further information was provided prior to survey exit. The policy and procedures titled "Specialized Rehabilitation Services" dated 4/6/05 indicated the facility will obtain and provide appropriate services if residents require specialized rehabilitative services such as physical therapy, speech-language pathology, occupational therapy and health rehabilitation services for mental illness and mental retardation as required in the resident's comprehensive plan of care.	F 825		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		5/17/19

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F 880	Continued From page 55	F 880		

and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 56 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, facility documentation review the facility failed to implement appropriate infection control practices during medication administration for 1 (Resident #42) of 46 residents in the survey sample. The facility staff failed to discard a pill that was dropped on Resident #42's bed during medication observation. The License Practical Nurse (LPN) placed the pill in the resident's left hand; the pill fell on the residents bed. The nurse retrieved the pill off of the bed with her bare hand and placed the pill in the resident's left hand. Resident #42 consumed the pill with a sip of water. The findings included: Resident #42's current Minimum Data Set (MDS), an admission assessment with an Assessment Reference Date (ARD) of 02/08/19 coded the resident a 10 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) that indicated moderate cognitive impairment. During the medication observation on 04/16/19 at approximately 4:28 p.m. LPN #1 pulled the following medications from the medication cart for Resident #42: Aspirin 81 mg (milligram)tablet,	F 880	1. Resident #42 was assessed and is without negative outcome. LPN #1 was re-educated on appropriate infection control practices during medication administration. 2. The Director of Nursing/designee has performed five medication administration observations of LPN #1 to ensure adherence to appropriate infection control practices during medication administration. 3. The Director of Education/designee has reeducated RNs and LPNs on Medication Administration. The in-service included, but was not limited to, re-educating nurses on proper infection control during administration of medications. 4. The Director of Nursing/designee will perform five random medication administration observations weekly for six weeks to ensure adherence to appropriate infection control practices during medication administration. The Director of Nursing/Designee will identify any patterns	

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F 880	Continued From page 57	F 880		

Magnesium oxide 400 mg tablet and Metoprolol 100 mg. The LPN went to Resident #42's bedside, elevated the head of the bed, then placed all three pills in the residents hand. The resident turned her hand to the side and her Metroprolol fell out of her hand, falling on her bed landing at her left side. The LPN searched the resident's bed by using her right hand feeling for the missing pill under the resident's left side; the LPN was not wearing gloves. The LPN removed the pill from the bed using her bare hand, placed the pill in the resident's left hand, then the resident took the pill. The resident replied, "That little pill drops out of my hand all the time."

A phone interview conducted with LPN #1 on 4/18/19 at 1:43 p.m. The surveyor asked, "What should you have been done with the pill once it was dropped in the resident's bed doing the medication observation on 04/18/19 at 4:28 p.m.,with this surveyor. The LPN stated, "I'm not really sure, I do not have an answer." The LPN stated, "Should I have done something else, I did not realize giving the resident her pill after it was dropped in the bed was wrong."

An interview was conducted with the Director of Nursing (DON) on 04/18/19 at approximately 2:33 p.m. The surveyor asked, "What is your expectations for your nurses if they drop a pill in the resident's bed while doing their medication pass." The DON stated, "I expect for the nurse to discard the medication, use hand sanitizer then pull another pill to be administered."

The facility administration was informed of the finding during a briefing on 04/18/19 at approximately 6:25 p.m. The facility did not present any further information about the findings.

or trends and report to the Quality Assurance and Performance Improvement committee at least quarterly.

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F 880	Continued From page 58 The facility's policy titled Infection Control-Hand Hygiene (Revision 03/22/18). Policy: Healthcare workers are to use effective hand hygiene frequently to help prevent the spread of microorganisms.	F 880		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, group interview and resident interviews, the facility staff failed to maintain an effective pest control program so that it is free of pests. The findings included: A complainant that involved Resident #80, a current resident, filed a complaint to the State survey and certification agency dated 3/4/19 that indicated cockroaches were seen in the resident's room, bathroom on the floors and ceilings. Although the complainant could not be reached via telephone, the resident was interviewable and stated during an interview on 4/17/19 at 8:50 a.m. that the complainant showed him the roaches that were in the bathroom and stated he had seen others in the room and throughout the facility. Resident #80 was admitted to the nursing facility on 3/16/18 with diagnoses that included kidney failure, high blood pressure history of stroke and	F 925	1. There was no evidence of roaches at the time of the inspection, therefore no corrective action could be taken to address the complaint. Facility staff was reeducated on the importance of maintaining an effective pest control program. 2. The Administrator/designee will inspect facility and continue to review pest control logs to ensure maintaining of an effective pest program. Any variance identified will be addressed immediately. 3. Administrator/designee will reeducate facility staff on maintaining an effective pest control program. The in-service included but not limited to the policy on pest control and the procedure to contact the pest control company for services as needed. 4. The Administrator/Designee will inspect the facility and pest control logs weekly for six weeks to ensure facility is	5/17/19

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F 925	Continued From page 59 left sided hemiplegia. Resident #80's most recent Minimum Data Set (MDS) assessment was a quarterly dated 3/6/19 and coded the resident with a score of 14 out of a possible 15 on the Brief Interview for Mental (BIMS) status which indicated the resident was intact with the cognitive skills for daily decision making. On 4/16/19 at 11:00 a.m., during the orientation tour, an interview was conducted with Resident #4. Resident #4 was admitted to the facility on 07/28/18. Resident #4's current Minimum Data Set (MDS), a quarterly assessment with a date of 01/11/19 coded the resident with a score of 13 out of a possible 15 on the Brief Interview for Mental (BIMS) status which indicated no cognitive impairment with the skills for daily decision making. Resident #4 stated there were lots of roaches in the building, especially at night crawling under her bed. She stated she hoped the facility doors would not be shut, but she just wanted the surveyors to know in order to help get rid of the roaches. During the group meeting on 4/17/19 at 9:30 a.m. with five residents that represented several facility units stated there were large water bugs/roaches in the showers and were seen periodically throughout the building and they sure the facility had a company in to spray for bugs. Review of the pest control logs the pest control company routinely on a biweekly basis services the building's kitchen, doorways, corners, carpeted areas, soffits and storage area with the	F 925	maintaining an effective pest control program. The Administrator/designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly.	

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F 925	Continued From page 60 targeted pest, "roaches." Some of the visits treatment is performed in resident bedrooms to include bathrooms. The GSM unit had recent monthly sightings by staff from February 2019 through April 2019. On 4/18/19 at approximately 5:00 p.m., the aforementioned resident concern about water bugs/roaches was shared with the Administrator. He stated he was aware of periodic problem areas, but they were treated by their current pest control company in addition to the biweekly treatments. At the exit conference, 4/18/19 at 6:30 p.m., the Administrator presented an infection control policy dated 4/12/18 that indicated a part of the prevention and control of infections was through pest control. No further information was provided prior to survey exit. Complaint Deficiency.	F 925		